STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146036	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Senior Living	1901 13th Street Herrin, IL 62948

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to provide safe transfers with mechanical lifts, implement interventions for falls, and follow facility policy to complete assessments and investigations post resident fall for 4 (R1, R2, R3, and R6) of 6 residents reviewed for accidents int the sample of 6. Findings include: 1. R1's Admission Record documented an admitted [DATE] with diagnoses that included: muscle weakness, chronic pain syndrome, morbid obesity, osteoarthritis of left and right knees. R1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/20/24 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 was cognitively intact. R1's MDS also documented R1 was dependent on staff for transferring. On 1/15/25 at 9:48 AM, R1 said he had fallen out of the sit to stand mechanical lift twice. R1 said the first fall happened when a Certified Nursing Assistant (CNA) was transporting R1 to the shower room from R1's room. R1 said he told the CNA prior to being transported R1 did not think his knees could hold him up long enough to transport him to the shower room. R1 said when he was almost to the door in his room he told the CNA his knees were going to give out and his knees buckled and R1 fell out of the sit to stand mechanical lift. R1 said the second fall out of the sit to stand mechanical lift was during a transfer from the bedside commode to his wheelchair. R1 said he did not recall how the second fall happened. R1 said once they had lifted R1 off the bedside commode the next thing he knew he was in the floor lying on top of a CNA. R1 said he had not sustained any injuries from either of his falls. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 at 2:46 PM, V18 (CNA) stated that on 12/2/24, she was caring for R1. V18 said she was transporting R1 from his room to the shower room on the sit to stand mechanical lift. V18 said she was comfortable transporting R1 to the shower room in the mechanical lift because a few days prior to 12/2/24 she had used the sit to stand mechanical lift to transport R1 from his room to the shower room. V18 said after getting R1 on the sit to stand mechanical lift she transported R1 to the door of his room and when she turned around to open the door, she heard R1 scream, turned to see R1 throw his arms into the air, slide out of the lift's sling falling onto the floor on his buttocks then rolling to his side. V18 said she yelled for help and V19 (CNA) and V20 (Licensed Practical Nurse/LPN) came into R1's room. V18 said V20 assessed R1 and told V19 and V18 it was safe to get R1 up. V18 said she and V19 used the sit to stand mechanical lift to lift R1 out of the floor and transfer R1 to his wheelchair. V18 said after R1 was back in his wheelchair she went to the front office and informed V1 (Administrator) and V2 (Director of Nursing/DON) of R1's fall from the sit to stand mechanical lift. V18 said V1 and V2 told V18 residents were not supposed to be transported around the facility in the sit to stand mechanical lift. V18 said she had worked previously as a CNA and was familiar with the sit to stand mechanical lift but had not received any training on how to use the sit to stand lift in the facility. V18 said she was hired in the facility to work in the activities department but had transitioned to working in the nursing department. R1's Electronic Medical Record (EMR) did not document any progress notes, post fall assessments, or updates to R1's care plan for R1's 12/2/24 fall from the sit to stand mechanical lift. R1's 12/2/24 Occupational Therapy Treatment Encounter Note(s) documented in part . (V2/DON) entered therapy room asking if patient could be 2 assist transfer with walker as (R1) is requesting this. (V2) states (R1) had fall off of sit to stand lift earlier this date . went to room to train CNAs with transfer training during toileting, when entering (R1's) room he is sitting edge of bed, (R1) visibly upset, due to being upset (R1) is not listening to safety education . (R1) stated throughout that the fall off of the sit to stand happened due to the CNAs attempting to transfer him too far instead of just putting him back into the wheelchair they attempted to bring him into the hallway to bring him to the shower and he took himself out of the sit to stand sling due to his knees unable to hold him up anymore and lowered himself to the floor, (V2) is aware of this and has provide education to CNAs that this is unsafe to do . On 1/16/25 at 11:39 AM, V20 (LPN) said she was the nurse caring for R1 on 12/2/24. V20 said she did not recall R1 falling out of the sit to stand mechanical lift. V20 said she did not recall any CNAs reporting to her any residents falling off the sit to stand mechanical lift. On 1/16/25 at 12:34 PM, V2 (DON) said a post fall assessment and a fall risk assessment should have been completed by V20. V2 said R1 should have had a fall risk care plan and a new intervention should have been put in place after the 12/2/24 fall. V2 said she was not sure why a post fall assessment, fall risk assessment, or fall risk care plan with fall interventions was not completed for R1's 12/2/24 fall. V2 said the facility did not have an investigation for the root cause of R1's 12/2/24 fall or interventions. V2 said due to V18 (CNA) being hired in the activities department and transitioning to the nursing department V18 had not received training on the sit to stand mechanical lift because this training was supposed to be completed on hire. V2 said all staff should receive training on all the mechanical lifts in the facility prior to the staff using the lift. The facility's mechanical lift training log documented V18 did not receive any training on mechanical lifts until 12/18/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Care Plan includes a focus area with a date initiated of 12/13/24 that documented (R1) has, had an actual fall with no injury during sit to stand transfer due to poor communication/comprehension and unsteady gait. R1's Care Plan also documented a Created on date of 1/15/25 for this focus area. Corresponding interventions included to Monitor/document/report PRN (as needed) x (times) 72h (hours) to MD (medical doctor) for s/sx (signs/symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, with a date initiated of 12/13/24; Nursing to monitor and report any behaviors of not following proper transfer technique. Report to nursing supervisor and or MD as needed, with date initiated of 12/15/24; PT (physical therapy) consult for strength and mobility, with date initiated of 12/13/24; and Resident and staff educated on proper transfer technique, with a date initiated of 1/15/25. Although the initiation date of the focus area and 3 of the 4 interventions were all listed as being initiated in December 2024, the Created on dates of the focus area and interventions were all listed with a date of 1/15/25. On 1/16/25 at 1:20 PM, V1 (Administrator) said R1 did not have a baseline care plan completed on R1's admission and did not have a care plan for fall prevention or safe transferring until she created one on 1/15/25. V1 said R1 should have had a baseline care plan completed on admission for fall prevention and transfer. V1 said R1 should have also had a revised resident centered care plan for fall prevention and for transfer safety. On 1/16/25 at 11:33 AM, V8 (CNA) said she was caring for R1 on 12/13/24 with V7 (CNA). V8 said on 12/13/24, V7 and V8 were transferring R1 from the bed side commode to his wheelchair when R1 started to slide out of the sit to stand mechanical lift. V8 said V7 tried to keep R1 in the mechanical lift but was not strong enough to hold R1 up. V8 said R1 let go of the mechanical lift and slid out of the sling and landed on top of V7. The facility produced a typed and signed statement by V7 dated 12/13/24 that documented in part . Around 2:30 PM (V8) and I (V7) went to get (R1) off the bedside commode . After using soap and water to clean him, while drying his bottom off, he started to stop standing as well, so we were hurrying to get him to the wheelchair and I used my legs to brace him from behind, just to get to the chair and right before we could turn into the chair he let go of the (sit to stand mechanical lift), so I lowered him to the floor with my body underneath his . R1's Post Fall Evaluation dated 12/13/24 documented R1 had a staff witnessed fall in his room while using the sit to stand mechanical lift and did not sustain any injuries and was not transferred to the hospital. R1's Post Fall Evaluation for 12/13/24 was not completed with the following areas left blank: Provider notified, contributing factors, medication changes, vital signs, skin, physical findings, MDS, care planning, clinical suggestions. R1's fall investigation incident description dated 12/13/24 documented Resident was being transferred from BSC (bed side commode) to w/c (wheelchair) by sit to stand, with 2 staff present. He became weak and raised his arms causing the sling to raise and he started sliding down, when CNA got behind him and supported to to (sic) the floor, He denied injury, ROM WNL (range of motion within normal limits). The report further documents Summary of events: Res (resident) was using sit to stand with 2 staff members who were transferring him from the bedside commode back to his chair when he got upset and let himself fall. Root cause: resident raised his arms up and slid out of the sit to stand. Resident was aware that this would happen. New intervention: Educated resident on sit to stand directions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's sit to stand mechanical lift's undated Owner's Operator and Maintenance Manual documented in part / . Section 1 - General Guidelines . The (company name) patient lift is NOT a transportation device. It is intended to transfer an individual from one resting surface to another (such as a bed or wheelchair). Moving a person suspended in a sling over ANY distance in NOT recommended . The facility's revised August 2008 Safe Lifting and Movement of Residents policy documented in part . 2. Staff responsible for direct resident care will be trained in the use of mechanical lifting devices. The manufacturer of purchased equipment shall provide initial staff training on the use of mechanical lifts, as well as on the routine checks and long-term maintenance of equipment. Subsequent trainings and retraining of staff on the use of mechanical lifting devices shall be conducted by designated team leaders. 3. Staff competency and the use of mechanical lift shall be assessed at least annually . 7. The transferring needs of residents shall be assessed on an ongoing basis. Resident transferring and lifting needs shall be documented in the care plan. Assessment of the residents transferring needs shall include: a. Mobility of the resident . b. Size of the resident c. Weight-bearing ability d. Cognitive status . 2. R6's Admission Record documented an admitted [DATE] with diagnoses including: metabolic encephalopathy, muscle weakness, morbid obesity, Alzheimer's Disease, dementia, and psychosis. R6's MDS assessment with ARD date of 11/18/24 documented a BIMS score of 9, indicating R6 was moderately cognitively impaired. The MDS Section J Health Conditions indicated R6 had a history of falls prior to admission. R6's 12/1/24 fall investigation documented in part . Root Cause: Resident attempted to stand up and (wheelchair) rolled out from under him . Intervention: Anti-Roll backs to w/c (wheelchair) . R6's Fall Risk assessment dated [DATE] documented R6 was at high risk for falls. R6's Care Plan includes a focus area initiated on 11/21/24 that documented (R6) has a history of falls and has had an actual fall here since admission, no injuries sustained. Other risk factors includes impaired mobility, incontinence, antipsychotic use, (diabetes mellitus), Alzheimer dementia. One of the corresponding interventions listed for this focus area documents 12/1/24: Anti-Roll backs to w/c (wheelchair) with a date initiated of 12/18/24. On 1/17/25 at 11:40 AM, R6 was sitting in the dining room in a wheelchair that did not have anti-roll backs present. On 1/17/25 at 11:45 AM, V4 (Nursing Supervisor/LPN) stated she was not sure if R6 was supposed to have anti-roll backs on his wheelchair. V4 said she would have to look at R6's Care Plan to know if R6 was supposed to have anti-roll backs on his wheelchair. Upon checking, V4 said R6's Care Plan did document R6 was supposed to have anti-roll backs on his wheelchair and she was not sure why it didn't. V4 said she would put in a work order to have anti-roll backs on R6's wheelchair. 49664 3. R3's Admission Record documents an admitted [DATE] including diagnoses of Type 2 Diabetes Mellitus, Dementia, Parkinson's Disease, Polyneuropathy, Chronic Obstructive Pulmonary Disease, and Hypertension. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's MDS with Assessment Reference Date (ARD) of 10/11/24 includes a BIMS score of 00, indicating severe cognition impairment. R3's MDS Section J, Health Conditions documents R3 has had falls resulting in injury since admission/entry or prior assessment. R3's Care Plan includes a Focus Area of R3 is at risk for falls related to: Confusion, Gait/balance problems, poor safety awareness, constantly removes 1 shoe and sock. Corresponding interventions included (but not limited to): 11/17/24 Anti-Roll backs to w/c (initiated 11/25/24) and 5/28/24 Maintenance to place anti slip floor strips to exit side of bed (initiated 6/5/24). On 1/16/2025 at 12:40 PM, R3 was propelling self in wheelchair up and down the hall. There were no anti-roll backs noted to be on R3's wheelchair at this time. On 1/17/2025 at 10:40 AM, R3's room was observed to have no anti slip floor strips beside exit side of bed. On 1/17/2024 at 10:42 AM, V15 (CNA) stated she cares for R3 most of the time. V15 stated I have never seen anti-skid strips placed by R3's bed. V15 stated sometimes R3 lays down after meals, R3 will usually lay down if we ask him to. V15 stated R3 wanders all over the facility in his wheelchair and stated she was not aware of the intervention of anti-roll backs on R3's wheelchair. On 1/17/2025 at 10:46 AM, V16 (Registered Nurse/RN) stated she was caring for R3 today. V16 stated she was not aware that R3 needed nonskid strips beside his bed. V16 stated that is probably an old intervention and the care plan needs updated. V16 stated she is notified of new interventions when she is told about them and after the meetings of the department heads who make the interventions. V16 stated after a resident falls the nurses are supposed to do a fall risk assessment in risk management. V16 stated this must be done after every single fall. On 1/17/2025 at 11:00 AM, R3 was propelling self in wheelchair down the hallway and there were again no anti-tippers noted to be on R3's wheelchair. A facility document titled Incidents lists R3's falls occurring on 10/25/2024, 11/17/2024 (2 occurrences on this date), 12/6/2024, 12/7/2024, and 12/11/2024. The only Fall Risk Assessment provided by the facility for R3 was dated 12/7/2024. The facility was unable to provide fall assessments completed for R3's other falls listed above. On 1/17/2025 at 12:10 PM, V1 (Administrator) verified there were no other fall risk assessments completed for R3's fall occurrences on 10/25/2024, the two falls on 11/17/2024, 12/6/2024, and 12/11/2024. R3's Care Plan did not include any new interventions for the falls that occurred on 10/25/24 and 12/6/24. 4. R2's Admission Record documents an admitted [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's MDS with ARD of 11/30/24 documents a BIMS score of 7, indicating severe cognitive impairment. Section GG documents R2 requires supervision with sit to stand and chair to chair transfer, and is substantial/maximal assistance with toileting/bathing, and walking 10 feet, 50 feet, and 150 feet. Section J, Health conditions documents R2 has had two or more falls with no injury since the prior assessment. A facility document titled Incident by incident documents R2 had falls on 11/15/2024, 11/25/2024, and 1/3/2025, 1/6/2025, and 1/12/2025. Electronic fall assessments dated 11/15/24 and 11/25/24 were found, however there were no fall assessments completed for the falls that occurred on 1/3/2025, 1/6/2025, and 1/12/25. R2's incident report dated 1/3/25 documents an immediate intervention of keep wheelchair at bedside with leg pedals off. R2's Care plan includes a Focus Area initiated on 6/13/24 of (R2) is at risk for falls related to confusion, psychoactive drug use, unsteadiness. Corresponding Interventions to the fall dates listed above included 1/6/2025: Tag alarm to be in place when (R2) is in bed as well as when in chair (date initiated 1/8/2025), 11/15/24: med review with family and provider, specifically her Haldol (date initiated 11/25/2024), and 11/25/2024: Assess for readiness to get up for meals (date initiated 12/18/2024). No interventions were added to the care plan regarding the falls that occurred on 1/3/24 or 1/12/24. On 1/17/2024 at 10:00AM V1 stated I cannot find any other fall assessments that were completed post falls for this resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's revised May 2024 Falls - Clinical Protocol policy documented in part, Under the heading Assessment and Recognition . 2. Fall Risk Assessment shall be completed . after a fall, and as clinically indicated . 6. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. a. falls should be categorized as a) those that occur while trying to rise from a seated or lying to an upright position, b) those that occur while upright and attempting to ambulate, c) other circumstances, such as sliding out of the chair or rolling from a low bed to the floor. They should be identified as witnessed or unwitnessed events. Under the heading Cause Identification . 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. a) Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b) Often, multiple factors in varying degrees contribute to a falling problem. C) After a first fall, the staff (And physician, if possible) Should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, further evaluation may not be needed. If the individual has difficulty or is unsteady in performing the test, additional evaluation should occur. 2. If the cause of a fall is unclear, if the fall may have a significant medical cause, such as a stroke or an adverse drug reaction (ARD), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. a. After more than one fall, the physician should review the resident's gate, balance, and current medications that may be associated with dizziness or falling . 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Under the heading Monitoring and Follow-Up . 4. If the individual continues to fall, the staff and physician will reevaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions .